Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,474.14 per Table of Disputed Services for date of service, 08/03/01.

   b. The request was received on 07/29/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Example EOBs from (Audit Company)
   e. Letter from (Contract Provider) dated 7/30/92
   f. Medical Records
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 09/10/02. The respondent did not respond to the additional documentation. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.

3. Notice of Letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter date stamped 9/09/02
   "…The methodology referenced by the Carrier on the EOB to support the amount of reimbursement has not been applied consistently. Specifically, the attached EOB's show Carrier's failure to provide consistent payment in accordance with its methodology. The Carrier has reimbursed varying payments based upon a '25% reduction in charges' for same or similar services, without any indication of any deviation from the usual method of determining the rate of reimbursement. However, in this instance the Carrier did not reimburse per the '25% reduction in charges' for code 'M' reductions. The Carrier is not providing reimbursement in accordance with TWCC Rule 133.304(i) that specifically requires that the Carrier pay the methodology consistently. The enclosed EOB's provide

sufficient evidence of the Carrier's failure to properly deny payment in accordance with Texas Administrative Code and Commission instructions. In addition, the 'methodology' allegedly applied to reduce payment by the Carrier has not been consistently applied or developed within the parameters of the Texas Administrative Code….Enclosed are also two differing responses from '(Audit Company)' regarding their 'methodologies' for reimbursing out-patient or ASC services. In one correspondence, (Audit Company) states that 'fair and reasonable' reimbursement is based upon 'Acute Care Inpatient Fee Guideline.' However, in the other correspondence, (Audit Company) stated that 'the primary element of the review process is the comparison of hospital charges to (Audit Company's) proprietary usual and customary universal chargemaster database.' The documentation evidences the application of differing methodologies for outpatient or ASC services….(Provider) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to fair and reasonable by (Provider) is at a minimum of 70% of billed charges…."

2. Respondent:
No Position Statement noted in the Commission's case file.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/03/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $9,139.64 for services rendered on the date of service in dispute above. The Carrier paid Requestor $4,472.00. The amount remaining in dispute is $4,474.14 as taken from the Table of Disputes Services.

4. The Carrier's EOB deny additional reimbursement as "M – NO MAR SET BY TWCC-REDUCED TO FAIR AND REASONABLE".

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes….HCPs shall bill their usual and customary

charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

Medical documentation submitted indicates these charges are for a Tenosynovectomy of the left wrist. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence in regards to fair and reasonable. The provider has submitted additional reimbursement data: three example EOBs for charges billed for similar services. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". There was no response from the Carrier noted in the Commission's case file. The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. In this case, the Requestor has provided some documentation (example EOBs from other Carriers) to support their position that the amount billed is fair and reasonable. Based on the letter dated 07/30/92 from (Contract Provider), outpatient services, per the contract, are payable at 70% of billed charges. The Provider has indicated 70% of the usual and customary charges are acceptable. Therefore, additional reimbursement of **$ 1,925.75** ($9,139.64 x .7 = 6397.75 - $4,472.00 = $1,925.75) **is** recommended.

The above Findings and Decision are hereby issued this 28th day of March 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$1,925.75** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 28th day of March 2003.

Carolyn Ollar
Supervisor - Medical Dispute Resolution Officer
Medical Review Division

CO/pd